PRINTED: 12/28/2010 FORM APPROVED

Bureau of Health Care Quality and Compliance

NAME OF PROVIDER OR SUPPLIER CASCADES OF THE SIERRA STREET ADDRESS. CITY. STATE, ZIP CODE 275 NEIGHBORHOOD WAY RENO, NV 89441 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TO NOT THE FINANCY OR LSC IDENTIFYING INFORMATION.) Y 000 Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that my be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 7/9/10. The State Licensure survey was conducted by the authority of NRS 449,150, Powers of the Health Division. The facility is licensed for 120 Residential Facility for Group beds for elderly and disabled persons, Category I and II residents.	AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Complaint #NV00025777 not substantiated.		by the Health Division prohibiting any criminactions, or other clair available to any party state, or local laws. This Statement of Dear result of a complair your facility on 7/9/10 survey was conducted 449.150, Powers of the facility is license for Group beds for el Category I and II residence.	n shall not be construed all or civil investigations ms for relief that my be y under applicable feder efficiencies was generated in the state Licensure and by the authority of NF he Health Division. In the State Licensure and the Health Division. In the Health Division and the Health Division. In the Health Division and the Health Division.	d as s, ral, ed as ed in RS				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE